**BEFORE THE APPEALS BOARD**
**FOR THE**
**KANSAS DIVISION OF WORKERS COMPENSATION**

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| **ROBERT A. FARROW**<br>Claimant | ) | |
| VS. | ) | |
| **MCCANN SUPPLY**<br>Respondent | ) | Docket No. 1,008,242 |
| AND | ) | |
| **LIBERTY INSURANCE**<br>Insurance Carrier | ) | |

## ORDER

Respondent and insurance carrier request review of the December 28, 2006 Award by Special Administrative Law Judge Marvin Appling. The Board heard oral argument on March 28, 2007.

### APPEARANCES

William L. Phalen of Pittsburg, Kansas, appeared for claimant. Janell Jenkins Foster of Wichita, Kansas, appeared for respondent and its insurance carrier.

### RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

### ISSUES

The Special Administrative Law Judge (SALJ) found the claimant sustained a 78 percent work disability based upon a "56 [percent] impairment of function and 100 percent wage loss."[1]

[1] SALJ Award (Dec. 28, 2006) at 4.

The respondent requests review of the following: (1) average weekly wage; (2) under/over payment of temporary total disability compensation; and, (3) nature and extent of disability. Respondent argues the claimant was employed as a part-time employee and only worked 5 days before the injury and, therefore, his average weekly wage should be $270.50 per a week. Respondent further argues the claimant has sustained a 28 percent work disability based upon a 56 percent task and a 0 percent wage loss.

Claimant argues he is permanently and totally disabled from any type of substantial gainful employment. Claimant further argues he was a full-time employee earning $7 an hour and averaged a 51-hour work week. In the alternative, the claimant argues the SALJ's Award should be affirmed.

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

Having reviewed the evidentiary record filed herein, the stipulations of the parties, and having considered the parties' briefs and oral arguments, the Board makes the following findings of fact and conclusions of law:

Respondent is an oil drilling company, and claimant was employed as a gofer. Claimant was injured on November 27, 2002, when he was helping his boss remove an oil rig from the back of a winch truck. He was hit in the head with a four-foot piece of steel pipe directly between his eyes. Claimant was thrown back about two feet, hitting a tree. He suffered a broken skull, a broken nose, crushed sinuses, neck and shoulder injuries. He was taken to a hospital in Bartlesville, Oklahoma, where he was treated for his injuries to his face, a CAT scan was taken of his head, and he was released that same day. Later, however, claimant began having more problems and was placed in the hospital in Sedan, Kansas, overnight and then was transferred to the Jane Phillips Regional Medical Center in Bartlesville, where he was kept for two days.

Claimant continues to complain of headaches twice a day, which he says last from an hour to all night long. He still has pain in his neck and pain and twitching in his shoulders. He has trouble with sleeplessness, saying he is in too much pain, is too anxious, or is too tired to sleep. He claims his senses of smell, taste, hearing, and sight have changed since the accident.

After his injury, claimant began having emotional problems. He has undergone psychiatric treatment with Dr. Faust Bianco Jr. and has been diagnosed with post-traumatic stress disorder (PTSD), depression, and anxiety. He said he is not motivated to do anything, cries two or three times a week for about 20 minutes, is anxious in public, gets tired easily, and has memory problems. He is still able to drive but does not drive often because he gets tired and has problems getting lost. Claimant testified he has had thoughts of suicide. He also said that since the accident, he has become afraid of bridges

and thinks they are too high and wide and that they could break. It bothers him to be around oil rigs because he is afraid of a repeat of his accident. When he sees an oil rig, he gets nervous and his hands sweat. Claimant said his personality has changed and he now becomes agitated and angry and yells at family members. He said that one time he harmed his sister. He did not yell or harm his family members before his accident.

Claimant's mother, Odessa Farrow, corroborated claimant's testimony that his personality has changed since the accident. She testified that claimant does not like to be around crowds, gets really angry, and yells at her. He gets loud and swears. Ms. Farrow confirmed that claimant had gotten lost when he's gone out by himself. She said that claimant is depressed and sits around watching television until something makes him angry. He'll play video games until he gets angry and stops. She said he cries every day. She confirmed that he has headaches on a daily basis, he is afraid of bridges, and he gets upset when he sees an oil rig.

Although claimant is receiving Social Security disability because of his injuries, he has looked for work and submitted lists of businesses he has contacted in his search for work. He contacted about four or five businesses a week but has had no job offers. He said he informed the businesses he contacted that he had a head injury suffered while working for respondent and that he had work restrictions. He also told the businesses about his headaches and emotional problems. Claimant said that the psychological restrictions placed on him do not allow him to return to work for respondent, and respondent has never offered him any kind of an accommodated job.

Dr. Steven E. Gaede is board certified in neurosurgery. He first saw claimant on December 31, 2002. Claimant was first referred to Dr. Gaede by Dr. Mark A. Robertson and was named claimant's authorized treating physician by Administrative Law Judge (ALJ) Nelsonna Potts Barnes. After examining claimant, Dr. Gaede diagnosed him with frontal sinus fracture with cosmetic deformity and a depressed skull fracture that was minimally compressed. Claimant was also diagnosed with post-concussion syndrome. He also identified evidence of PTSD.

During Dr. Gaede's treatment, claimant complained of neck pain with radiation into his right arm but Dr. Gaede informed claimant that he should concentrate on his cranial problems, as they were more pressing. However, Dr. Gaede thought there was a possibility that claimant had injured his neck. He indicated that he would make arrangements for claimant to be seen for an orthopedic evaluation, but that was not approved.

Claimant continued to complain of headaches, memory loss and emotional outbursts. Dr. Gaede recommended cosmetic surgery and exploratory surgery to repair any dural defects that might be found, but claimant was leery of surgery and could not

agree to have the surgery. Dr. Gaede recommended treatment of the defect in claimant's forehead but said he put off making any firm decisions pending treatment of claimant's psychological problems. Claimant eventually decided he would not pursue cosmetic correction of his forehead defect.

Dr. Gaede last saw claimant on November 13, 2003, at which time he stated he did not believe claimant needed further neurosurgical followup and stated that claimant's major problem appeared to be his PTSD. At that time, he noted claimant still had pain at the right side of his trapezius and some lateral facet tenderness at the mid cervical spine.

Dr. Gaede, in his letter of January 19, 2004, noted that claimant was at maximum medical improvement from a neurosurgical viewpoint, which specifically excluded claimant's psychological problems. He evaluated claimant using the AMA *Guides*[2] and noted that claimant had a loss of supporting structure of the face and a cutaneous disorder. Dr. Gaede rated claimant as having a 10 percent permanent partial impairment to the whole body. This rating was only for claimant's head injury and would be over and above any rating claimant received as a result of his PTSD or for the orthopedic injuries to his neck, shoulder or spine. Dr. Gaede did not believe that claimant required any restrictions as a result of his skull fracture. He reviewed a task list and did not identify any tasks that claimant would have lost as a result of the injury to his frontal lobe.

Dr. Michael E. Ryan is board certified by the American Academy of Psychiatry and Neurology and the American Association of Electromyography and Electrodiagnosis. He examined claimant on September 21, 2004, at the request of the respondent. Dr. Ryan took a history from claimant concerning this accident and reviewed his medical records. Claimant complained of continued depression, PTSD, shoulder pain, neck pain, and headaches. Claimant said the pain in his neck and shoulders would radiate from the right side up over the head and develop into a headache. The headaches used to be extreme, but claimant said the use of Flexeril offers him significant relief. Claimant said his sense of taste is okay, but his sense of smell has been altered since his injury.

Dr. Ryan diagnosed claimant with a post closed head injury with depressed skull fracture; fracture through the right frontal sinus. It appeared claimant sustained a concussion and post-concussive syndrome. Dr. Ryan recommended an MRI of claimant's cervical spine to rule out cervical spine pathology. That MRI was done on January 17, 2005, and showed no evidence of any degenerative disk disease, herniated disk, or significant cervical spine disease. Dr. Ryan suggested there was no evidence of any

[2] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

neurologic impairment from claimant's injury relative to his cervical spine and that claimant's neck and shoulder pain are more musculoskeletal.

Dr. Ryan testified that he believes claimant suffered some injury and has some ongoing problems as a result. He does not believe, however, that those injuries caused any functional impairment. Dr. Ryan indicated that claimant has resolved many of his symptoms of concussion and post-concussion syndrome. From a strictly neurologic perspective, Dr. Ryan would not assign any permanent work restrictions and claimant would not have any task loss. Dr. Ryan did not give an opinion concerning whether claimant had an orthopedic impairment or a psychiatric impairment and deferred to specialists in those fields to render those opinions.

At the request of Dr. Gaede, claimant was seen by Dr. Terry G. Shaw for a neuropsychological evaluation. Dr. Shaw found that there was evidence that claimant was suffering from PTSD and recommended a psychologist trained in working with patients with that disorder. Dr. Faust Bianco is a clinical rehabilitation neuropsychologist and has a Ph.D. in clinical psychology. Claimant was referred to Dr. Bianco who first saw him on June 2, 2003. At that time, claimant met the criteria for PTSD, and Dr. Bianco commenced treatment for that condition. He did not do any educational or intellectual testing of claimant because Dr. Shaw had done that. That testing showed that claimant is functionally illiterate with an IQ of 73 and is borderline mentally retarded.

Dr. Bianco's initial diagnosis of claimant was severe range PTSD related to his work-related accident, as well as adjustment disorder with mixed anxiety and depression that was related to the disability. He found that claimant also suffered from headaches and pain in the ocular area around the eye in the sphenoid sinus area. Dr. Bianco saw claimant for 41 two-unit sessions between June 6, 2003, and January 30, 2004.

Dr. Bianco recommended that claimant receive vocational evaluation and training because claimant wanted to go back to work. However, due to his functional illiteracy, he believed claimant would need hands-on training and monitoring.

By April 30, 2004, Dr. Bianco found claimant's PTSD and adjustment disorder to be in the mild range of psychopathology. Claimant still suffered from headaches and had been in pain management. Claimant continued to express a desire to enter the workforce, but Dr. Bianco stated he needed to be monitored for his PTSD condition, which is prone to relapse. Dr. Bianco felt claimant's adjustment disorder issues were related to his headaches.

Dr. Bianco discharged claimant on February 28, 2005. His PTSD and adjustment disorder had improved from being in the severe range to being within functional limits of psychopathology. Claimant continued to suffer from headaches and was still in pain

management. The headaches had improved. Dr. Bianco opined that claimant should remain on antidepressant medication indefinitely. Dr. Bianco stated that claimant's PTSD symptoms "are significantly improving, with only avoidance of oil rigs and pumps remaining as symptoms."[3] Dr. Bianco released claimant as being at psychological medical maximum improvement, with the caveat that he could still possibly relapse.

Using the AMA *Guides*, Dr. Bianco rated claimant as having a 35 percent impairment to the body as a whole as a result of his work-related accident.

In discussing Dr. Mitchel A. Woltersdorf's evaluation of claimant, Dr. Bianco stated that the criteria Dr. Woltersdorf used to diagnose claimant as being a malingerer was invalid. Dr. Bianco said that Dr. Woltersdorf assessed claimant for malingering with the Validity Indicator Profile (VIP) and the Structured Interview of Reported Symptoms (SIRS) test. Dr. Bianco said the VIP should not be administered to persons with an obvious history of mental retardation. Dr. Bianco also said that Dr. Woltersdorf found claimant showed probable malingering on two indices of the SIRS test. Dr. Bianco said that the people who produced the SIRS test do not endorse the use of this criteria because there is an 18.2 percent false positive rating. Rather, the people who produced the SIRS test believe the most accurate indicator of definite feigning is the presence of three or more scales in the probable feigning range. Dr. Bianco said that in his opinion, claimant was not malingering.

Dr. Woltersdorf is board certified in neuropsychology. He examined claimant on December 3, 2003, at the request of respondent. Dr. Woltersdorf agreed with Dr. Shaw that at the time he saw claimant, cognitively he was performing at the same level at which he had been performing before the pipe hit him.

Dr. Woltersdorf and Dr. Shaw disagreed, however, in terms of claimant's emotional harm. Dr. Shaw felt claimant had PTSD. Dr. Woltersdorf did not. Dr. Woltersdorf said that PTSD is something that develops after a horrific event, while claimant was just hit in the head and had no loss of consciousness or post-traumatic amnesia. Dr. Woltersdorf said claimant's head injury could have been no worse than a mild traumatic brain injury (TBI), and there is no scientific support for PTSD after a mild TBI.

Dr. Woltersdorf said that Dr. Bianco's diagnoses of PTSD and adjustment disorder are redundant. PTSD is a severe disorder due to an external stressor and adjustment disorder is a mild disorder from an external stressor. Dr. Woltersdorf said if you choose one, you cannot choose the other.

[3] Bianco Depo., Ex. 3 at 8.

Dr. Woltersdorf administered a VIP examination to claimant. He said the VIP test is so simple that even people with severe TBI, the mentally retarded, and Alzheimer's patients can take it. Claimant was given only the nonverbal part of the test because his nonverbal skills are better than his verbal skills. The results of that test showed that claimant was not being genuine in terms of his abilities.

Dr. Woltersdorf also administered a SIRS test, which was given to rule out the issue of emotional malingering. The test presents with symptoms that could be true or false and all the patient has to do is be honest and choose symptoms that he genuinely has. There are a number of scales on the test, and claimant triggered two scales, one being rare symptoms, meaning he was picking symptoms that do not truly exist in a physiological sense for emotional harm. Claimant also triggered the inconsistency index at the probable malingering level, which indicates he was picking symptoms that were either conflicting or contradictory.

Dr. Woltersdorf said that claimant's mother was in the room when he interviewed claimant but was not allowed in the room while claimant was being tested. Dr. Woltersdorf said he had to ask claimant's mother to remain quiet during the interview because she was being too influential. He said that when he questioned claimant, claimant would look to her for the answer.

Dr. Woltersdorf testified that claimant had no TBI residuals. He concluded that the injury that occurred was too mild to have created any PTSD, and if claimant had any adjustment disorder, he covered it up on examination by malingering. He testified that he would give claimant a 0 percent psychological impairment rating as a result of his injury. Claimant would also have no work restrictions from a cognitive or emotional perspective.

During claimant's interview with Dr. Woltersdorf, he did not report any symptoms that were consistent with PTSD. If not for the results of the SIRS test showing claimant to be a malingerer, Dr. Woltersdorf would have diagnosed him with an adjustment disorder. He would not have diagnosed claimant with PTSD. He did not think claimant is maliciously malingering but is adaptational malingering. Dr. Woltersdorf felt claimant was not intelligent or sophisticated enough to maliciously deceive. However, he believes claimant is highly suggestible and has likely been led to believe that he needs to be off work and be treated. Dr. Woltersdorf believes claimant should be encouraged to return to some form of work amenable to his chronic cognitive limitations.

Dr. Edward Prostic, a board certified orthopedic surgeon, examined claimant on November 17, 2002, at the request of claimant's attorney. Dr. Prostic took a history from claimant, including the facts of the accident and his medical treatment. Claimant denied previous problems with his head, neck or upper extremities. Claimant complained to Dr. Prostic of bifrontal headaches, sensitivity to light and loud sounds, ache at the back of his

neck with difficulty looking upward, and ache at his right shoulder with popping and weakness. Claimant also reported memory loss and intermittent disorientation.

Upon examination, Dr. Prostic found that claimant had a depressed area of his forehead directly above the nose with a healed laceration. Alignment of the cervical spine was satisfactory and no tenderness was noted. Range of motion was satisfactory. No neurologic deficit was noted. In examining claimant's right upper extremity, Dr. Prostic noted there was no heat, swelling, erythema or atrophy. There was no tenderness, and range of motion was complete. Impingement signs were negative. Dr. Prostic found weakness of flexion and abduction, as well as mild winging of the scapula. He also found tenderness at the sternoclavicular joint. Dr. Prostic diagnosed claimant with partial separation at the right acromioclavicular joint, mild winging of the right scapula suggestive of traction injury to the long thoracic nerve, tenderness at the right sternoclavicular joint; and aggravated degenerative disk disease in his neck.

At the request of claimant's attorney, Dr. Prostic saw claimant a second time on April 27, 2005. He took an updated history from claimant that included treatment by Dr. Bianco and evaluations by Dr. Woltersdorf and Dr. Ryan. Claimant continued to have headaches and difficulties with eyesight, hearing, and smell. He continued to have tenseness about his neck and shoulders with intermittent twitching. Upon examination, Dr. Prostic found that claimant's cervical spine was still in alignment but that he had tenderness in the midline at approximately C4-C7. Range of motion was satisfactory except for a right tilt that was restricted 15 degrees. There was local pain with nerve root irritability signs. Dr. Prostic found no neurologic deficit other than the winging of the right scapula. There was a 3/4 inch decrease in circumference of the right upper arm as compared to the dominant left. There was mild weakness of flexion and abduction and moderately severe weakness of external rotation of the right shoulder.

Dr. Prostic diagnosed claimant with a depressed skull fracture, sinus fracture, pneumocephalus and injuries to his cervical spine and right shoulder. Based on the AMA *Guides*, Dr. Prostic assigned claimant a 15 percent permanent partial impairment of the body as a whole on a functional basis for orthopedic impairment of his neck and shoulder. Dr. Prostic testified that if his 15 percent impairment for claimant's orthopedic injuries is combined with Dr. Bianco's 35 percent impairment as a result of claimant's PTSD and Dr. Gaede's 10 percent permanent partial impairment as a result of claimant's laceration at the midline forehead with depressed skull fracture, claimant would have a combined permanent partial impairment of 51 percent to the body as a whole. If claimant is not found to be suffering from PTSD, the combined orthopedic impairment and impairment for the depressed skull fracture would combine to 24 percent permanent partial impairment to the body as a whole.

Dr. Prostic placed permanent restrictions on claimant that he should not return to work that requires more than minimal use of his right hand above shoulder height. He should avoid lifting weights greater than 40 pounds to waist height or 20 pounds to shoulder height occasionally. He should also avoid repetitious or forceful pushing, pulling or reaching with his right hand. Dr. Prostic reviewed a task list prepared by Karen Terrill and opined that of the 25 unduplicated items on the list, claimant is unable to perform 14 for a 56 percent task loss.

Brenda Umholtz, a vocational rehabilitation counselor, met with claimant at the request of respondent to provide vocational evaluation services. Together, she and claimant prepared a list containing 54 tasks claimant performed in the 15-year period before his injury.

Ms. Umholtz conducted a wage loss assessment on claimant based his transferable skills and the average hourly wage for occupations in his geographical area. Jobs Ms. Umholtz listed that she felt claimant could perform were food preparation; food preparation worker/server; assembler of small parts; patch worker; and floor worker/production helper. She came up with an overall average per hour that claimant could expect to earn in those occupations of $8.09 per hour working a 40-hour week.

Ms. Umholtz did not check any Kansas job surveys for any specific county in the state regarding claimant. She broke down her labor market information into claimant's geographical area of Southeast Kansas, but not including Wichita. Ms. Umholtz stated a reasonable commute would be 50 miles one way, depending on the amount of money a person was earning. She admitted that of the 12 or 13 counties that comprised her job survey information, some of the counties would be outside the 50-mile radius. Ms. Umholtz called the Parsons Chamber of Commerce to ask about manufacturing plants in that area and was given the names of four businesses. She did not contact those businesses to check on whether they were hiring.

Karen Terrill, a vocational rehabilitation consultant, met with claimant on May 17, 2005, at the request of claimant's attorney. Together with claimant, she generated a list of 25 tasks claimant performed in the 15-year period before his injury.

Ms. Terrill testified that because Drs. Prostic and Bianco indicated that claimant would not be able to engage in work, he would earn 0 wages, a 100 percent wage loss. If she hypothesized that claimant could not return to work that required more than minimal use of his right hand above his shoulder, that he should avoid lifting weights greater than 40 pounds to the waist or 20 pounds to the shoulder occasional, and that he should avoid repetitious or forceful pushing, pulling or reaching right-handed, claimant could earn up to $6.50 per hour. In making that conclusion, Ms. Terrill was looking only at claimant's orthopedic restrictions and not for claimant's head trauma or psychological problems.

**Average Weekly Wage**

Claimant testified he made $7 per hour and worked about 51 hours per week. He said he did not receive overtime pay for any hours over 40 hours per week. He testified that he had worked for respondent for about two months before he was injured. Claimant's mother testified and corroborated his testimony regarding the hours he worked and that he worked at least six days a week. And she further testified that claimant had worked for respondent longer than just four or five days. Consequently, claimant argues his average weekly wage is $357, making his weekly compensation rate $238.01. It was stipulated that respondent paid temporary total disability compensation at the rate of $186.67 for a total of 117 weeks. Claimant therefore contends temporary total disability compensation was underpaid by $51.34 per week for a total of $6,006.78.

Respondent offered a wage statement as an exhibit to the regular hearing which showed that claimant had only worked 4.5 days for respondent before being injured and had earned a total of $270.50 during that period of time. The wage statement also indicated that claimant was a part-time employee. Respondent argues that claimant's average weekly wage is $270.50, making his weekly compensation rate $180.34. Since claimant's temporary total compensation benefits were paid at the rate of $186.67, respondent is claiming an overpayment in the amount of $741.38.

However, when respondent offered the wage statement as an exhibit, claimant's attorney objected on the basis of foundation, after which respondent's attorney stated:

> [Respondent's attorney]: Yes, Judge. If I need to take some foundation testimony, I will do that.
>
> THE COURT: Okay, then I'm going to sustain claimant's objection and you'll need to do that. I would like you to do it anyway because, as [claimant's attorney] pointed out, there's only five days of employment on here.
>
> [Respondent's attorney] And I don't disagree at all, Judge, I think we need some clarification all the way around on what his wage is.[4]

Other than claimant's and his mother's testimony at the regular hearing, there was no further testimony regarding claimant's average weekly wage as respondent never offered any additional testimony to provide foundation or further explanation of the purported wage statement. The Board affirms the SALJ's finding that claimant has met his burden of proof to establish he was a full-time employee with an average weekly wage of $357 per week.

[4] R.H. Trans. (Sept. 14, 2005) at 45.

**Nature and extent of disability**

The claimant argues that he is permanently and totally disabled. Permanent total disability exists when an employee, on account of the employee's injury, has been rendered completely and permanently incapable of engaging in any type of substantial, gainful employment.[5]

An injured worker is permanently and totally disabled when rendered "essentially and realistically unemployable."[6] The injuries claimant suffered do not raise a statutory presumption of permanent total disability under K.S.A. 44-510c(a)(2); therefore, it is the responsibility of the trier of fact to determine the existence, extent and duration of an injured worker's incapacity.[7]

"The existence, extent and duration of an injured workman's incapacity is a question of fact for the trial court to determine."[8] It is the function of the trier of fact to decide which testimony is more accurate and/or credible and to adjust the medical testimony with the testimony of the claimant and others in making a determination on the issue of disability. The trial court must make the ultimate decision as to the nature and extent of injury and is not bound by the medical evidence presented.[9]

Dr. Gaede rated claimant with a 10 percent functional impairment based upon the loss of supporting structure to the face as well as a cutaneous disorder. But the doctor did not believe claimant required restrictions as a result of his skull fracture nor did he suffer any task loss as a result of the injury to his frontal lobe. Dr. Ryan did not believe claimant suffered any impairment as a result of his skull and right frontal sinus fractures and likewise concluded that limited to those injuries claimant did require restrictions nor suffer a task loss. Dr. Prostic rated claimant with a 15 percent functional impairment based upon his neck and shoulder injuries. As a result of those injuries the doctor imposed restrictions and opined claimant suffered a 56 percent task loss.

The evidence does not support a finding that claimant is permanently and totally disabled solely as a result of his skull and sinus fractures as well as his injuries to his neck

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[5] K.S.A. 44-510c(a)(2).

[6] *Wardlow v. ANR Freight Systems*, 19 Kan. App. 2d 110, 113, 872 P.2d 299 (1993).

[7] *Id*. at 112.

[8] *Boyd v. Yellow Freight Systems, Inc.*, 214 Kan. 797, 803, 522 P.2d 395 (1974).

[9] *Tovar v. IBP, Inc.*, 15 Kan. App. 2d 782, 785, 817 P.2d 212, *rev. denied* 249 Kan. 778 (1991).

and shoulders. But Drs. Gaede, Ryan and Prostic all deferred to the psychologists regarding claimant's mental impairment and whether it would preclude employment.

After his injury, claimant began having emotional problems. He would lose control and become agitated and angry and yell at family members which he did not do before his accident. He is not motivated to do anything, cries two or three times a week for about 20 minutes, is anxious in public, gets tired easily, and has memory problems. He is still able to drive but does not drive often because he gets tired and has problems getting lost. Claimant testified he has had thoughts of suicide. He also said that since the accident, he has become afraid of bridges and thinks they are too high and wide and that they could break. It bothers him to be around oil rigs because he is afraid of a repeat of his accident. When he sees an oil rig, he gets nervous and his hands sweat. Claimant's mother, Odessa Farrow, corroborated claimant's testimony that his personality has changed since the accident.

Dr. Shaw diagnosed claimant with PTSD and referred him to Dr. Bianco for treatment. Dr. Bianco also diagnosed claimant with PTSD due to the work-related accident and provided an extended course of treatment. Conversely, Dr. Woltersdorf concluded claimant did not suffer from PTSD and was malingering.

Although the claimant is functionally illiterate with an IQ of 73 and is borderline mentally retarded he was able to work and did not display the emotional problems he now suffers until after the work-related accident. Ultimately, Dr. Bianco, the treating psychologist provided by respondent concluded claimant was not realistically employable without additional vocational training and then on-the-job monitoring. Dr. Bianco felt claimant would present a potential safety risk to himself because while undergoing treatment he had attempted to clean up debris after a storm and had severely cut his leg with a chainsaw and later while cleaning up family property had started a fire with a blowtorch which destroyed a trailer used for storage. Dr. Bianco was further concerned claimant would be unable to have enough sustained concentration that he would be able to focus on work tasks even working at an entry-level position.

Dr. Woltersdorf felt that PTSD only develops after a life threatening event but concluded claimant was only hit in the head. This disregards claimant's testimony that he thought he was going to bleed to death after the head injury which lacerated his skull with facial bleeding so severe that he couldn't see.

Dr. Woltersdorf concluded that claimant was malingering solely based upon testing he had performed on the claimant. Dr. Bianco noted that the type of tests Dr. Woltersdorf had given claimant are specifically not to be used with a person with an obvious history of mental retardation. Moreover, Dr. Bianco further testified that the SIRS testing requires

three findings in the probable feigning range whereas Dr. Woltersdorf only found two. And the two he found were suspect. Dr. Bianco testified:

> Q. Sure.
>
> A. False positives mean almost 20 percent of the people using just two probable feigning scales, you'll diagnose 20 percent of the people malingering that are not malingering, so they do not endorse that.
>
> Rather, we believe the most accurate indicator of definite feigning is the presence of three or more scales in the probable feigning range. That was not present.
>
> He [Dr. Woltersdorf] goes on to use some specifics of one of these probable feigning scales which are unusual or highly infrequent symptoms. One of them that he says - - well, he stated that he had increased occurrence of sore throat and cold since his accident. This man had a fractured sphenoid sinus. He was draining all the time. That's clear in the record. When you have sinus drainage, you have more sore throats.
>
> He stated that he - - since the accident he has episodes of sudden blindness. Remember this is an individual who has a 72 IQ. In his flashbacks, he would see the pole striking him in the head and go through the experience of blacking-out, and having the blood in his eyes, and said I couldn't - - I can't see.
>
> It's my opinion that to a person with a mental retardation that kind of experience would be an episode of total blindness. Doctor Shaw says that he did not go in to in-depth psychological written examinations because of his [claimant] third-grade reading level. He [Dr. Woltersdorf] concurs that he had a second-grade reading level, and that even when Dr. Shaw attempted to read to him, he had comprehension problems.
>
> So my point here is that he [Dr. Woltersdorf] is stating - - and he goes on to state that the person's flat out malingering, but he's using two invalid bases for his - - for his diagnosis. The SIRS, I'll go through it, says you're clearly not to use this with a mentally-retarded person. That there are some studies that it warrants further study, and that it might be able to be used, but they don't endorse it.
>
> So given his particular circumstances, the criteria that he uses for his diagnosis are invalid, and I don't think they're evidential.
>
> Q. He [Dr. Woltersdorf] uses these two tests; the SIRS and the Validity Indices Profile - -
>
> A. Yes.
>
> Q. - - you've got both of the manuals and both manuals said these tests shouldn't be used?
>
> A. Yes. Or in the case of the SIRS that you should not use just two, as he states clearly, two subscales of probable malingering to make a diagnosis. That you have

> to have three or more, but it states clearly that there's a caveat against using it with mentally-retarded persons because neither one of these have been normed for mentally-retarded folks.
>
> And as a neuropsychologist, one should clearly know that you should use norms, and if you don't have norms, say, "this might suggest" or "would refer person to for further study." "I have concerns about his exaggerating symptomatologies". But to state flat out that he's malingering, I have a problem with.
>
> Q. Is Mr. Farrow malingering, Doctor?
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> A. Not in my opinion and not in Doctor Shaw's opinion and not in his neurosurgeon's opinion.[10]

In this case, the Board finds Dr. Bianco's opinion more persuasive than Dr. Woltersdorf.

The Court, in *Wardlow*, looked at all the circumstances surrounding his condition including the serious and permanent nature of the injuries, the extremely limited physical chores he could perform, his lack of training, his being in constant pain and the necessity of constantly changing body positions as being pertinent to the decision whether the claimant was permanently totally disabled.

In this instance, the claimant has been diagnosed by Dr. Bianco as being unable to engage in active substantial gainful employment. Dr. Bianco concluded that the claimant's mental condition, as a result of his work-related injury, rendered him unable to return to gainful employment irrespective of his physical stature.

The claimant's worsened condition is directly traceable to his work-related injury. His mental and physical limitations lead the Board to the conclude that he is essentially and realistically unemployable and thus incapable of substantial and gainful employment. It is the Board's determination that the claimant has met his burden of proof to establish that he is permanently and totally disabled. Consequently, the SALJ's Award is modified to reflect claimant is entitled to an award of permanent total disability award.

## AWARD

**WHEREFORE**, it is the decision of the Board that the Award of Special Administrative Law Judge Marvin Appling dated December 28, 2006, is modified to an award of permanent total disability.

[10] Bianco Depo., at 41,42,43.

The claimant is entitled to 117 weeks temporary total disability compensation at the rate of $238.01 per week or $27,847.17 followed by permanent total disability compensation at the rate of $238.01 per week not to exceed $125,000 for a permanent total general body disability.

As of April 27, 2007, there would be due and owing to the claimant 117 weeks of temporary total disability compensation at the rate of $238.01 per week in the sum of $27,847.17 plus 113.29 weeks of permanent total disability compensation at the rate of $238.01 per week in the sum of $26,964.15 for a total due and owing of $54,811.32, which is ordered paid in one lump sum less amounts previously paid. Thereafter, the remaining balance in the amount of $70,188.68 shall be paid at $238.01 per week until fully paid or until further order of the Director.

**IT IS SO ORDERED.**

Dated this 30th day of April 2007.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: William L. Phalen, Attorney for Claimant
Janell Jenkins Foster, Attorney for Respondent and its Insurance Carrier
Marvin Appling, Special Administrative Law Judge
Nelsonna Potts Barnes, Administrative Law Judge